

(2) Another person may apply for a Living Benefit on the insured individual's behalf if all of the following conditions are met:

(i) The insured's physician must certify that the insured individual is physically or mentally incapable of making an election;

(ii) The applicant must have power of attorney or a court order authorizing him or her to elect a Living Benefit on the insured individual's behalf;

(iii) The applicant must place his or her own signature on the application and attach it to a true and correct copy of the power of attorney or court order authorizing the applicant to make the election on the insured individual's behalf; and

(iv) The applicant must either be the insured individual's sole beneficiary or attach a true and correct copy of each beneficiary's written and signed consent.

(c)(1) OFEGLI reviews the application, obtains certification from the insured's employing office regarding the amount of insurance and the absence of an assignment, and determines whether the individual meets the requirements to elect a Living Benefit.

(2) If OFEGLI needs additional information, it will contact the insured or the insured's physician.

(3) Under certain circumstances, OFEGLI may require a medical examination before making a decision. In these cases, OFEGLI is financially responsible for the cost of the medical examination.

(d)(1) If the application is approved, OFEGLI sends the insured a check or makes an electronic funds transfer to the insured's account for the Living Benefit payment and an explanation of benefits.

(i) Until the check has been cashed or deposited, or before the electronic funds transfer has been received, the individual may change his or her mind about electing a Living Benefit; if this happens, the individual must mark the check "void" and return it to OFEGLI.

(ii) Once the insured individual has cashed or deposited the payment, the Living Benefit election becomes effective and cannot be revoked; OFEGLI then sends explanations of benefits to the insured's employing office, so it

can make the necessary changes in withholdings and deductions.

(2) If the application is not approved, OFEGLI will notify the insured individual and the employing office. The decision is not subject to administrative review; however, the individual may submit additional medical information or reapply at a later date if future circumstances warrant.

[75 FR 60586, Oct. 1, 2010]

Subpart L [Reserved]

PART 875—FEDERAL LONG TERM CARE INSURANCE PROGRAM

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AUTHORITY: 5 U.S.C. 9008.

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Subpart A—Administration and General Provisions

§ 875.101 Definitions.

This part is written as if the reader were an applicant or enrollee. Accordingly, the terms “you,” “your,” etc., refer, as appropriate, to the applicant or enrollee.

In this part, the terms *annuitant*, *employee*, *member of the uniformed services*, *retired member of the uniformed services*, and *qualified relative* have the meanings

set forth in section 9001 of title 5, United States Code, and supplement the following definitions:

Abbreviated underwriting is a type of underwriting that asks fewer questions about your health status than with full underwriting to enable the Carrier to determine whether your application for coverage will be approved. The Carrier may also require review of your medical records, a phone interview, or an in-home interview.

Actively at work means:

(1) That as an active workforce member other than a member of the uniformed services you meet all of the following conditions:

(i) You are reporting for work at an approved work location and you work at least one-half of your regularly scheduled hours for that day; and

(ii) You are able to perform all the usual and customary duties of your employment on your regular work schedule.

(2) For a member of the uniformed services, that you are on active duty and are physically able to perform the duties of your position.

Carrier means a qualified carrier as defined in section 9001 of title 5, United States Code, with which OPM has contracted to provide long term care insurance coverage under this section. A Carrier may designate 1 or more administrators to perform some of its obligations.

Domestic partner is defined as a person in a domestic partnership with an employee, annuitant, member of the uniformed services, or retired member of the uniformed services.

Domestic partnership means:

(1) A committed relationship between two adults, of the opposite sex or same sex, in which the partners—

(i) Are each other's sole domestic partner and intend to remain so indefinitely;

(ii) Maintain a common residence, and intend to continue to do so (or would maintain a common residence but for an assignment abroad or other employment-related, financial, or similar obstacle);

(iii) Are at least 18 years of age and mentally competent to consent to a contract;

(iv) Share responsibility for a significant measure of each other's financial obligations;

(v) Are not married or joined in a civil union to anyone else;

(vi) Are not a domestic partner of anyone else;

(vii) Are not related in a way that would prohibit legal marriage in the U.S. jurisdiction in which the domestic partnership was formed;

(viii) Provide documentation demonstrating fulfillment of the requirements of paragraphs (1)(i) through (vii) of this definition as prescribed by OPM; and

(ix) Certify that they understand that willful falsification of the documentation described in paragraph (1)(viii) of this definition may lead to disciplinary action and the recovery of the cost of benefits received related to such falsification and may constitute a criminal violation under 18 U.S.C. 1001.

(2) You or your domestic partner must notify the employing office if at any time between the time of application and the time coverage is scheduled to go into effect, any of the conditions listed in paragraphs (1)(i) through (vii) of this definition are no longer met, in which case a domestic partnership is deemed terminated. Such notification must be made as soon as possible, but in no event later than thirty calendar days after such conditions are no longer met.

Eligible individual means an annuitant, active workforce member, member of the uniformed services, retired member of the uniformed services or qualified relative, as defined in section 9001 of title 5, United States Code.

Enrollee means an eligible individual whose application for coverage the Carrier has approved and whose coverage is in effect.

FLTCIP means the Federal Long Term Care Insurance Program.

Free look means that within 30 days after you receive the Benefit Booklet, you may cancel your coverage if you are not satisfied with it and receive a refund of any premium you paid. It will be as if the coverage was never issued.

Full underwriting is the more comprehensive type of underwriting under the FLTCIP, which requires that you answer many questions about your

health status to enable the Carrier to determine whether your application for coverage will be approved. The Carrier may also require review of your medical records, a phone interview, or an in-home interview.

Stepchild(ren), as set forth in section 9001 of title 5, United States Code, means the child(ren) of the spouse or domestic partner of an employee, annuitant, member of the uniformed services, or retired member of the uniformed services.

Stepparent means any person, other than your mother or father, who is currently married to one of your parents, or, if one of your parents is dead, a person who was married to that parent at the time of that parent's death.

Underwriting requirements means the information about your current health status and history and other information that you must provide to the Carrier with your application for coverage to enable the Carrier to determine your insurability.

Workforce member means a Federal civilian or Postal employee, member of the uniformed services, Federal annuitant, retired member of the uniformed services, or member of any other eligible group, as defined in section 9001 of title 5, United States Code. An active workforce member is one who is currently employed or is on active duty.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30606, May 27, 2005; 80 FR 66786, Oct. 30, 2015; 81 FR 10057, Feb. 29, 2016]

§ 875.102 Where do I send benefit claims?

You must submit your benefit claims to the FLTCIP Carrier or its designee.

§ 875.103 Do I need to authorize release of my medical records when I file a claim?

Yes, if you file a claim for benefits, the Carrier needs to have a valid authorization from you to release your medical records.

§ 875.104 What are the steps required to resolve a dispute involving benefit eligibility or payment of a claim?

(a) If you dispute the Carrier's denial of your eligibility for benefits or your claim for payment of benefits, you

must first send a written request for reconsideration to the Carrier no later than 60 days from the date of its decision.

(b) The Carrier must provide you with written notice of its review decision no later than 60 days after the date it receives your reconsideration request.

(c) If the Carrier upholds its denial (or does not respond within 60 days), you have the right to appeal its reconsideration decision directly to the Carrier. You must make this appeal in writing within 60 days from the date of the Carrier's notice upholding its decision. You will be notified of the decision on your appeal in writing no later than 60 days from receipt of your appeal request.

(d) If a denial of your eligibility for benefits or a denial of your claim is upheld upon appeal due to the evaluation of your medical condition/functional capacity, the Carrier will inform you that you may request that an independent third party, mutually agreed to by OPM and the Carrier, review the decision. You must make this request in writing within 60 days from the date of the notice informing you of the appeal decision. The independent third party must notify you in writing of its decision no later than 60 days from the Carrier's or its designee's receipt of your request for appeal to the third party. This is the final administrative remedy available to you. The decision of the independent third party is final and binding on the Carrier.

(e) You may seek judicial review of the final administrative denial of a claim. Such action may not be brought prior to exhaustion of the administrative process provided in this section. To pursue such judicial review, you must bring legal action against the Carrier in an appropriate United States district court within 2 years from the date of the final decision. You may not sue OPM, the independent reviewer, or any other entity. If you prevail in court, your recovery is limited to the amount of benefits payable under your benefit booklet and schedule of benefits.

(f) The procedures described in paragraphs (a), (b), (c), (d), and (e) of this section apply only if you have valid

coverage under the FLTCIP. If the Carrier determines that your coverage was based on an erroneous application and voids the coverage as described in § 875.408 of this part, these provisions do not apply. The Carrier will provide you with information on your review rights in its rescission letter (letter voiding your coverage).

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005; 72 FR 12037, Mar. 15, 2007]

§ 875.105 May OPM correct errors?

OPM may order correction of administrative errors after reviewing evidence and finding that it would be against equity and good conscience not to do so.

§ 875.106 What responsibilities do agencies have under this Program?

Federal agencies and uniformed services establishments are responsible for:

- (a) Providing access to information about the FLTCIP to eligible individuals;
- (b) Responding to questions from the Carrier, including questions on the employment status of an applicant or enrollee;
- (c) Providing reports as OPM requires;
- (d) Complying with Benefits Administration Letters and other OPM issuances/instructions; and
- (e) Deducting premiums as authorized by a workforce member and as requested by the Carrier, when possible.

§ 875.107 What are OPM's responsibilities as regulator under this Program?

Consistent with the authority and discretion given to OPM by the FLTCIP law, OPM's responsibilities include those functions typically associated with, and preemptive of, State insurance regulatory authorities such as:

- (a) Reviewing and approving the content and format of materials associated with the FLTCIP pursuant to section 9008(d) of title 5, United States Code;
- (b) Reviewing and approving rates, forms, and marketing materials; and
- (c) Determining the qualifications of enrollment personnel and the Program administrator(s).

§ 875.108 If the Carrier approves my application, will I get a certificate of insurance?

If the Carrier approves your application for coverage, OPM and/or the Carrier will make available to you a benefit booklet and schedule of benefits with complete coverage information, which will serve as your proof of insurance. You will also get a copy of your approved application for coverage.

§ 875.109 Is there a delegation of authority for resolving contract disputes between OPM and the Carrier?

For the purpose of making findings of fact and to the extent that conclusions of law may be required under any proceeding conducted in accordance with the provisions of the disputes clause included in the FLTCIP master contract, OPM delegates this function to the Armed Services Board of Contract Appeals.

Subpart B—Eligibility

§ 875.201 Am I eligible as a Federal civilian or Postal employee?

(a) If you are a Federal civilian or Postal employee whose current position conveys eligibility for Federal Employees Health Benefits under part 890 of this chapter, you are also eligible to apply for coverage, with the following exceptions:

(1) If you are a District of Columbia employee or retiree, you are not eligible to apply for coverage, regardless of whether you are eligible for Federal Employees Health Benefits coverage. There is a related exception, however: D.C. government employees and retirees who were first employed by the D.C. government before October 1, 1987 are eligible to apply for coverage.

(2) If you are a Tennessee Valley Authority employee or retiree, you are eligible to apply for coverage, even though you may not be eligible for Federal Employees Health Benefits coverage.

(3) If you are a Non-Appropriated Fund (NAF) employee or retiree you are eligible to apply when the Secretary of Defense determines such eligibility for the NAF instrumentality that employs you, and you will be

treated the same as a Federal civilian employee or retiree (as applicable) under this Part.

(b) If you are a Federal civilian or Postal employee whose current position is excluded from Federal Employees Health Benefits eligibility under § 890.102 of this chapter, you are excluded from applying for coverage unless paragraph (a)(2) of this section applies.

(c) If you are an annuitant reemployed by the Federal Government, you may apply for coverage as an employee.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.202 Am I eligible as a Federal annuitant?

If you are a Federal annuitant, including a survivor annuitant, a deferred annuitant, or a compensationner, you are eligible to apply for coverage. Separated Federal employees with title to a deferred annuity may apply for coverage, even if they are not yet receiving that annuity.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.203 Am I eligible if I separated under the FERS MRA+10 provision?

If you have separated from service under the FERS Minimum Retirement Age and 10 years of service (MRA+10) provision of 5 U.S.C. 8412(g), and have postponed receiving an annuity under that provision, you are eligible to apply for coverage under this part. For underwriting purposes, you will be considered an annuitant.

§ 875.204 Am I eligible as a member of the uniformed services?

(a) You are eligible to apply for coverage if you are on active duty or full-time National Guard duty for more than a 30-day period.

(b) You are eligible to apply for coverage if you are a member of the Selected Reserve, which consists of:

(1) Drilling Reservists and Guardsmembers assigned to Reserve Component Units;

(2) Individual Mobilization Augmentees who are Reservists assigned to Reserve Component billets in Active Component units (you may be

performing duty in a pay or non-pay status); and

(3) Active Guard and Reserve members who are full-time Reserve members on full-time National Guard duty or active duty in support of the National Guard or Reserves.

(c) You are not eligible to apply for coverage if you belong to the Individual Ready Reserve. The Individual Ready Reserves includes Reservists who are assigned to a Voluntary Training Unit in the Naval Reserve and Category E in the Air Force Reserve.

§ 875.205 Am I eligible as a retired member of the uniformed services?

(a) You are eligible to apply for coverage if you are a retired member of the uniformed services entitled to retired or retainer pay (including disability retirement pay).

(b) You are eligible to apply for coverage if you are a retired reservist who is currently receiving retirement pay.

(c) You are eligible to apply for coverage as a retired (“grey”) reservist, even if not yet receiving retirement pay.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.206 As a new active workforce member, when may I apply?

(a) As a new, newly eligible, or returning active workforce member, you may apply as follows:

(1) If you are a new active workforce member entering a position that conveys eligibility, you may apply for coverage within 60 days after becoming eligible.

(2) If you are entering a position that conveys eligibility as an active workforce member from a position that did not convey eligibility, you may apply for coverage within 60 days after becoming eligible.

(3) If you return to active service after a break in service of 180 days or more to a position that conveys eligibility, you may apply for coverage within 60 days after becoming eligible.

(b) Your spouse may also apply during that 60-day period after you become eligible.

(c) The underwriting requirements that will be required will be those applicable to active workforce members

and their spouses during the last open season for enrollment before the date of your application.

(d) After the 60-day period ends, you may still apply for coverage, as may your spouse, but full underwriting requirements will apply.

(e) If your employing office determines that you were unable, for a cause beyond your control, to submit an application during the initial 60-day period, you may submit an application within 60 days after your employing office advises you of that determination. Similarly, your employing office may make this determination if your spouse is unable to submit an application during the same time period for a cause beyond his/her control. This employing office authority only applies within 6 months after the beginning date of the initial eligibility period. The underwriting requirements will be as specified in paragraph (c) of this section.

(f) Your other qualified relatives may apply for coverage at any time. They will be subject to full underwriting requirements.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.207 What happens if I am in non-pay status during an open season?

(a) If you return to a pay status from nonpay status during the open season, you have 60 days from the date of your return, or until the end of the open season, whichever gives you more time, to apply for coverage pursuant to the open season underwriting requirements for Federal civilian or Postal employees and members of the uniformed services.

(b) If you return to pay status from nonpay status after the open season, you have 60 days from the date of your return to apply for coverage pursuant to the underwriting requirements specified for Federal civilian or Postal employees and members of the uniformed services in the immediately preceding open season.

(c) Paragraphs (a) and (b) of this section apply only when you have been in nonpay status for more than one-half of an open season, unless you went into nonpay status for a reason beyond your control.

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§ 875.208 May I apply as a qualified relative if the person on whom I am basing my eligibility status has died?

You may not apply as a qualified relative if the workforce member on whom you are basing your qualified relative status died prior to the time you apply for coverage, unless you are receiving a survivor annuity as the spouse or an insurable interest annuity as the domestic partner of a deceased workforce member. In this case, your adult children and your current spouse or domestic partner are also considered to be qualified relatives.

[80 FR 66786, Oct. 30, 2015]

§ 875.209 How do I demonstrate that I am eligible to apply for coverage?

(a) When you submit your application for coverage, you must make known your status as a member of an eligible group.

(b) If the Carrier finds that you misrepresented your eligibility status, the Carrier has the right to void your coverage and return to you any premiums you paid, without interest. The incontestability provisions in § 875.408 do not apply to this section.

[68 FR 5534, Feb. 4, 2003, as amended at 72 FR 12037, Mar. 15, 2007]

§ 875.210 What happens if I become ineligible after I submit an application?

(a) You must be eligible at the time of your application and at the time your coverage is scheduled to go into effect. Except as noted in paragraph (b) of this section, if you lose your status as part of an eligible group before your coverage goes into effect, you are no longer eligible for FLTCIP coverage. You are required to inform the Carrier that you are no longer eligible.

(b) In two instances, you will continue to be eligible for coverage even if you lose your status as part of an eligible group after you submit an application for coverage, but before your coverage becomes effective. The two instances are:

(1) When you are involuntarily separated from Federal civilian service (except for misconduct) or from the uniformed services (except for a dishonor-

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able discharge). In either of these events, your qualified relatives will continue to be eligible.

(2) When you are the qualified relative of a workforce member who dies.

§ 875.211 What happens if my eligibility status changes after I submit my application?

(a) If you applied as an active workforce member, and separate from service under the MRA+10 provisions of 5 U.S.C. 8412(g), or retire after you submit an application for coverage, but before your coverage becomes effective, you must reapply as an annuitant and submit to full underwriting requirements.

(b) If you applied as an active workforce member, and otherwise separate from service, but you are a qualified relative of another workforce member, you must reapply based on the additional underwriting requirements specified for that type of qualified relative.

[70 FR 30607, May 27, 2005]

§ 875.212 Is there a minimum application age?

Yes, there is a minimum application age. You must be at least 18 years old at the time you submit an application for coverage.

§ 875.213 May I apply as a qualified relative if I am the domestic partner of an employee or annuitant?

(a) You may apply for coverage as a qualified relative if you are a domestic partner, as described in § 875.101 of this chapter. As prescribed by OPM, you will be required to provide documentation to demonstrate that you meet these requirements, and you must submit to full underwriting requirements. However, as explained in § 875.210 of this chapter, if you lose your status as a domestic partner, and therefore a qualified relative, before your coverage goes into effect, you are no longer eligible for FLTCIP coverage.

(b) For purposes of this part, the term “domestic partner” is a person in a domestic partnership with an employee or annuitant of the same sex. The term “domestic partnership” is defined as a committed relationship between two adults, of the same sex, in which the partners—

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(1) Are each other's sole domestic partner and intend to remain so indefinitely;

(2) Have a common residence, and intend to continue the arrangement indefinitely;

(3) Are at least 18 years of age and mentally competent to consent to a contract;

(4) Share responsibility for a significant measure of each other's financial obligations;

(5) Are not married to anyone else;

(6) Are not a domestic partner of anyone else;

(7) Are not related in a way that, if they were of opposite sex, would prohibit legal marriage in the State in which they reside; and

(8) Certify that they understand that willful falsification of the documentation described in paragraph (a) of this section may lead to disciplinary action and the recovery of the cost of benefits received related to such falsification and may constitute a criminal violation under 18 U.S.C. 1001.

[75 FR 30268, June 1, 2010, as amended at 80 FR 66786, Oct. 30, 2015]

Subpart C—Cost

§ 875.301 Is there a Government contribution toward premiums?

There is no Government premium contribution toward the cost of long term care insurance.

§ 875.302 What are the options for making premium payments?

(a) Premium payments may be made by Federal payroll or annuity deduction, uniformed services retirement pay deduction, by pre-authorized debit, or by direct billing.

(b) You must continue to make premium payments when they are due for your coverage to stay in effect.

§ 875.303 How are premium payment errors corrected?

(a) If the Carrier finds that you have underpaid the premium rate for your age and/or level of coverage, you must pay retroactive premiums to the Carrier for the amount due. If you fail to pay back premiums within the time provided by the Carrier to correct the

error, the Carrier may terminate your coverage.

(b) If the Carrier finds that you have overpaid premiums, the Carrier will either reimburse you or reduce a future premium payment(s) by the amount of the overpayment.

(c) If you die while you have coverage, any premiums paid for the period beyond the date of your death will be refunded to your estate or to an alternate payee. If there is no estate, the Carrier will determine whether to pay the refund to an alternate payee. If you cancel your coverage, any premiums paid in advance for the period following the effective date of your cancellation will be refunded to you.

(d) Any premiums you paid will be returned if you cancel coverage within the "free look" period specified in the benefit booklet.

§ 875.304 How does the Carrier account for FLTCIP funds?

The Carrier must keep account of all funds received under this section separate from all other funds. The Carrier may use FLTCIP funds only for purposes specifically related to the FLTCIP.

Subpart D—Coverage

§ 875.401 How do I apply for coverage?

(a) To apply for coverage, you must complete the application in a form appropriate for your eligibility status as prescribed by the Carrier and approved by OPM.

(b) If you are the qualified relative of a workforce member, you may apply for coverage even if the workforce member does not apply for coverage.

§ 875.402 When will open seasons be held?

(a) The first open season for enrollment under this section began July 1, 2002, as described in a FEDERAL REGISTER Notice (67 FR 43691, June 28, 2002), including the open season ending date(s) and which eligible individuals may apply based on abbreviated underwriting.

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(b) There are no regularly scheduled open seasons for long term care insurance. OPM will announce any subsequent open seasons via a FEDERAL REGISTER Notice. The Notice will include the requirements for applicants during the open season.

(c) In situations where new eligibility groups are added to the Program, and OPM determines that it is appropriate to have an open season, OPM will provide notice and set the requirements for a special open season limited to those eligible individuals.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.403 May I apply for coverage outside of an open season?

If you are eligible for coverage, you may submit an application at any time outside of an open season. You will be subject to full underwriting requirements. The only exceptions to the full underwriting requirements outside of an open season are described in § 875.206 and § 875.405.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.404 What is the effective date of coverage?

(a) The effective dates of coverage under open season enrollments will be announced in a FEDERAL REGISTER Notice that announces open season dates.

(b)(1) If you enroll at any time outside of an open season, your coverage effective date is the 1st day of the month after the date your application is approved.

(2) If you are an active workforce member and you are applying for coverage under abbreviated underwriting, you also must be actively at work at least 1 day during the calendar week immediately before the week which contains your coverage effective date for your coverage to become effective. You must inform the Carrier if you do not meet this requirement. In the event you do not meet this requirement, the Carrier will issue you a revised effective date, which will be the 1st day of the next month. You also must meet the actively at work requirement for any revised effective date for coverage to become effective,

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or you will be issued another revised effective date in the same manner.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30607, May 27, 2005]

§ 875.405 If I marry, may my new spouse apply for coverage; if I become a domestic partner, may my new domestic partner apply for coverage; and may other qualified relatives apply for coverage?

(a) *Marriage.* (1) If you are an active workforce member and you have married, your spouse is eligible to submit an application for coverage under this section within 60 days from the date of your marriage and will be subject to the underwriting requirements in force for the spouses of active workforce members during the most recent open season. You, however, are not eligible for abbreviated underwriting because of your marriage. You, your spouse, or both you and your spouse may apply for coverage during this 60-day period, but full underwriting will be required for you. After 60 days from the date of your marriage, you and/or your spouse may still apply for coverage but will be subject to full underwriting.

(2) If you are an active workforce member and you have entered into a domestic partnership, your domestic partner is eligible to submit an application for coverage under this section at any time from the commencing date of your domestic partnership and will be subject to full underwriting requirements. You are not eligible for abbreviated underwriting because of your domestic partnership. You, your domestic partner, or both you and your domestic partner may apply for coverage at any time, but full underwriting will be required for both of you.

(b) *Domestic partnership.* The new spouse or domestic partner of an annuitant or retired member of the uniformed services may apply for coverage with full underwriting at any time following the marriage or commencing date of the domestic partnership.

(c) *Other qualified relatives.* Other qualified relative(s) of a workforce member may apply for coverage with full underwriting at any time following

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the marriage or commencing date of the domestic partnership.

[80 FR 66786, Oct. 30, 2015]

§ 875.406 May I change my coverage?

(a) You may make the following changes to your coverage:

(1) You may apply to increase your coverage at any time. Full underwriting is required, except when an open season allows abbreviated underwriting.

(2) If you increase your coverage by adding to your daily benefit amount, the premiums for the additional coverage will be based on your age, prevailing premium rates, and coverage rules in effect at the time you purchase the additional coverage.

(3) For other types of coverage increases, your entire premium will be based on your age, prevailing premium rates, and coverage rules in effect at the time you purchase the increased coverage. Any increase in coverage will take effect on the 1st day of the month following the date the Carrier approves your request for an increase.

(b) You may decrease your coverage at any time, although any decrease will be subject to coverage rules at the time of the decrease. Decreased coverage takes effect on the 1st day of the month after the Carrier receives your request. You will not receive any refund of premiums paid for coverage you held before the decrease; however, your subsequent premiums will be reduced based on your new, lower level of coverage. The Carrier will refund or credit any portion of premium paid in advance for the period following the date on which you decrease your coverage.

(c) You may cancel your coverage at any time.

(1) If you cancel during the free look period, your premiums will be refunded to you.

(2) If you cancel your coverage at any time other than during the free look period, cancellation will take effect on your requested cancellation date or at the end of the period covered by your last premium payment, whichever occurs first. You will not receive any refund of premiums paid, other than any premiums paid in advance for the period following the effective date of your cancellation of coverage, and you

will not have to pay any more premiums unless you owed retroactive premiums.

§ 875.407 Who makes insurability decisions?

The Carrier determines the insurability of all applicants. The Carrier's decision may not be appealed to OPM.

§ 875.408 What is the significance of incontestability?

(a) Incontestability means coverage issued based on an erroneous application may remain in effect. Such coverage will not remain in effect under any of the following conditions:

(1) If your coverage has been in force for less than 6 months, the Carrier may void your coverage upon a showing that information on your signed application that was material to your approval for coverage is different from what is shown in your medical records.

(2) If your coverage has been in force for at least 6 months but less than 2 years, the Carrier may void your coverage upon a showing that information on your signed application that was material to your approval for coverage is different from what is shown in your medical records and pertains to the condition for which benefits are sought.

(3) After your coverage has been in effect for 2 years, the Carrier may void your coverage only upon a showing that you knowingly and intentionally made a false or misleading statement or omitted information in your signed application for coverage regarding your health status that was material to your approval for coverage.

(4) If your coverage is voided, as described in paragraph (a)(1), (a)(2), or (a)(3) of this section, no claims will be paid. In addition, the provisions of § 875.104 relating to the procedures for resolving a dispute involving benefits eligibility or claims denials do not apply to your situation. You may request a review by the Carrier if you believe that your coverage was voided in error. You must submit your request in writing to the Carrier within 30 days of the date of the rescission letter (letter voiding your coverage).

(b) Your coverage can be contested at any time when the Carrier finds that

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you were not an eligible individual at the time you applied and were approved for coverage.

(c) If the Carrier voids coverage after it has paid benefits, it cannot recover the benefits already paid.

(d) Incontestability does not apply when you have not paid your premiums on a timely basis.

[68 FR 5534, Feb. 4, 2003, as amended at 72 FR 12037, Mar. 15, 2007]

§ 875.409 Must I provide an authorization to release medical information?

You must provide the Carrier with an authorization to release medical information when requested. The Carrier may deny a claim for benefits or void your coverage if the Carrier does not receive an authorization to release medical information within 3 weeks after its request (4 weeks for those outside the United States).

§ 875.410 May I continue my coverage when I leave Federal or military service?

If you are an active workforce member, your coverage will automatically continue when you leave active service, as long as the Carrier continues to receive the required premium when due. However, once you leave active service, you are no longer eligible for any abbreviated underwriting provided during any future open season.

[68 FR 5534, Feb. 4, 2003, as amended at 72 FR 12038, Mar. 15, 2007]

§ 875.411 May I continue my coverage when I am no longer a qualified relative?

If you are already enrolled as a qualified relative, you may continue your FLTCIP coverage if you subsequently lose qualified relative status (such as upon divorce), as long as the Carrier receives the required premium when due.

§ 875.412 When will my coverage terminate?

Except as provided in paragraph (e) of this section, your coverage will terminate on the earliest of the following dates:

(a) The date you specify to the Carrier that you wish your coverage to end;

(b) The date of your death;

(c) The end of the period covered by your last premium payment if you do not pay the required premiums when due, after a grace period of 30 days; or

(d) The date you have exhausted your maximum lifetime benefit. (However, in this event, care coordination services will continue.)

(e) Termination of a domestic partnership does not terminate insurance coverage as long as the Carrier continues to receive the required premium when due.

[68 FR 5534, Feb. 4, 2003, as amended at 80 FR 66787, Oct. 30, 2015]

§ 875.413 Is it possible to have coverage reinstated?

(a) Under certain circumstances, your coverage can be reinstated. The Carrier will reinstate your coverage if it receives proof satisfactory to it, within 6 months from the termination date, that you suffered from a cognitive impairment or loss of functional capacity, before the grace period ended, that caused you to miss making premium payments. In that event, you will not be required to submit to underwriting. Your coverage will be reinstated retroactively to the termination date but you must pay back premiums for that period. The premium will be the same as it was prior to termination.

(b) If your coverage has terminated because you did not pay premiums or because you requested cancellation, the Carrier may reinstate your coverage within 12 months from the termination date at your request. You will be required to reapply based on full underwriting, and the Carrier will determine whether you are still insurable. If you are insurable, your coverage will be reinstated retroactively to the termination date and you must pay back premiums for that period. The premium will be the same as it was prior to termination.

§ 875.414 Will benefits be coordinated with other coverage?

Yes, benefits will be coordinated with other plans, following the coordination of benefits (COB) guidelines set by the National Association of Insurance Commissioners. The total benefits from all plans that pay a long term

care benefit to you should not exceed the actual costs you incur. The other plans that are considered for COB purposes include government programs, group medical benefits, and other employer-sponsored long term care insurance plans. Medicaid, individual insurance policies, and association group insurance policies are not taken into consideration under this provision.

PART 880—RETIREMENT AND INSURANCE BENEFITS DURING PERIODS OF UNEXPLAINED ABSENCE

Subpart A—General

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Subpart B—Procedures

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Subpart C—Continuation of Benefits

- 880.301 Purpose.
- 880.302 Payments of CSRS or FERS benefits.
- 880.303 FEHBP coverage.
- 880.304 FEGLI coverage.

AUTHORITY: 5 U.S.C. 8347(a), 8461(g), 8716, 8913.

SOURCE: 63 FR 10291, Mar. 3, 1998, unless otherwise noted.

Subpart A—General

§ 880.101 Purpose and scope.

(a) The purpose of this part is to establish a uniform standard that OPM will use in its administration of benefits for CSRS, FERS, FEHBP and FEGLI in cases in which an annuitant becomes a missing annuitant.

(b) This part establishes the procedures that OPM will follow to—

- (1) Determine—
 - (i) Who is a missing annuitant,
 - (ii) When a missing annuitant has died,

(iii) When benefits will be paid in missing annuitant cases, and

(iv) FEHBP coverage for family members of a missing annuitant; and

(2) Make adjustments to CSRS and FERS benefit payments, FEHBP coverage and premiums, and FEGLI benefit payments and premiums after a determination that a missing annuitant is dead.

(c) This part applies only to situations in which an individual who satisfies the statutory definition of an annuitant under section 8331(9) or section 8401(2) of title 5, United States Code, disappears and has not been determined to be dead by an authorized institution. This part does not apply to—

(1) An employee, regardless of whether the absence is covered by subchapter VII of chapter 55 of title 5, United States Code; or

(2) A separated employee who either—

(i) Does not meet the age and service requirements for an annuity, or

(ii) Has not filed an application for annuity.

§ 880.102 Regulatory structure.

(a) This part contains the following subparts:

(1) Subpart A contains general information about this part and related subjects.

(2) Subpart B establishes the procedures that OPM will follow in missing annuitant cases.

(3) Subpart C establishes the methodologies that OPM will apply in determining continuations of coverage and amounts of payments in missing annuitant cases.

(b) Part 831 of this chapter contains information about benefits under CSRS.

(c) Part 838 of this chapter contains information about benefits available to former spouses under court orders.

(d) Parts 841 through 844 of this chapter contain information about benefits under FERS.

(e) Part 870 of this chapter contains information about benefits under FEGLI.

(f) Part 890 of this chapter contains information about benefits under FEHBP.